U.S. Department of Labor

Office of Administrative Law Judges
36 E. 7th St., Suite 2525
Cincinnati, Ohio 45202

(513) 684-3252
(513) 684-6108 (FAX)

Issue Date: 03 January 2006

Case No.: 1997-BLA-1447

BRB No.: 03-843 BLA

In the Matter of:

WINSTON GIBBS, JR.,
Claimant

v.

ARCH OF KENTUCKY, INC.,
Employer

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS,
Party-in-Interest

DECISION AND ORDER ON REMAND - DENIAL OF BENEFITS

On August 27, 2003, the undersigned issued a Decision and Order on Remand Denying Employer's Request for Modification. On appeal by the Employer, the Decision was affirmed in part, vacated in part, and the case was remanded by Decision and Order of the Benefits Review Board ("Board"), BRB No. 03-0843 BLA, issued on September 22, 2004.

Procedural History

The Claimant filed a claim for benefits on February 22, 1993. In a Decision and Order dated September 20, 1995, Judge Levin awarded benefits. In a Decision and Order dated July 24, 1996, the Board vacated Judge Levin's finding with regard to the date of onset of the Claimant's total disability and remanded the case for further reconsideration of that issue. On August 20, 1996, the Employer filed a Petition for Modification with the Director. On August 16, 1997, the Director recommended denial of the Employer's request for modification and the case was transferred to the undersigned.

In a Decision and Order dated November 9, 1998, the Employer's request for modification was denied and benefits were awarded. On appeal by the Employer, the Board, in a Decision

and Order dated September 27, 2000, vacated the undersigned's finding that the evidence was insufficient to establish a mistake in a determination of fact under § 725.310 (2000), and remanded the case for a *de novo* review of the evidence to determine whether modification was warranted. The Board instructed that if a mistake in determination of fact was found, further consideration must be given to whether re-opening the case would render justice under the Act.

In a Decision and Order on Remand dated May 9, 2001, the undersigned held that the Employer's newly submitted evidence should have been developed and presented in the initial litigation before Judge Levin and that no mistake in determination of fact had been made. Benefits were again awarded. In a Decision and Order dated April 26, 2002, the Board affirmed the May 9, 2001, Decision and Order on Remand.

The Employer filed a Motion for Reconsideration. In a Decision and Order on Reconsideration dated October 31, 2002, the Board held that on further reflection, the May 9, 2001, Decision and Order was inconsistent with the Board's remand instructions to conduct a *de novo* review and did not follow the relevant modification authority. The Board remanded the case for further consideration.

The undersigned issued a Decision and Order on Remand dated August 27, 2003, reviewing the newly submitted medical opinions and finding that they did not establish a mistake in determination of fact. On appeal by the Employer, the Decision was affirmed in part, vacated in part, and the case was remanded by Decision and Order of Board, BRB No. 03-0843 BLA, issued on September 22, 2004.

In its Decision and Order, the Board stated that:

> The administrative law judge erred in failing to properly conduct a *de novo* review of the record in considering whether a mistake in a determination of fact was established pursuant to Section 725.310 (2000). In considering modification for the third time in this case, the administrative law judge did not weigh the newly submitted evidence together with the previously submitted evidence on the contested issues of the existence of pneumoconiosis under Section 718.202(a)(4), and disability causation under Section 718.204(b)(2)(iv), but rather rejected employer's evidence….

> While the administrative law judge stated that he carefully considered the newly submitted opinions of Drs. Broudy, Powell, Wright, Wier, Caizzi, Fino and Branscomb, and summarized the opinions … he did not weigh these opinions against the previously submitted opinions and make credibility determinations. Instead … the administrative law judge provided the same rationale employed in his prior, May 9, 2001, Decision and Order….
>
> We vacate, therefore, the administrative law judge's decision denying modification. We grant employer's request to transfer this case to another administrative law judge for a *de novo* consideration of the evidence on the issue of whether employer established a mistake in determination [of] fact pursuant to Section 725.310(2000). On remand, if the administrative law judge assigned to this case finds that the evidence of record is sufficient to establish a mistake in a determination of fact pursuant to Section 725.310(2000), he must then consider whether reopening this claim will "render justice under the Act" ….

Gibbs, BRB No. 03-0843 BLA at 5-6.

Findings of Fact and Conclusions of Law

The Findings of Fact and Conclusions of Law as stated in the original Decision and Order are adopted herein except to the extent they were found to be erroneous by the Benefits Review Board, or to the extent that they are inconsistent with the findings and conclusions made in this Decision and Order on Remand.

No previous Decision and Order has addressed the Miner's smoking history. In the hearing before Judge Levin, the Claimant testified that he smoked for about 20 years, at a rate of one pack per day, quitting in 1988-1989 (DX 53 at 32). This testimony is supported by the physician's records (See, *e.g.*, DX 64; EX 1). I find that the Miner has a smoking history of 20 years, at a rate of one pack per day of cigarettes, quitting around 1988-1989.

Assignment to a New Administrative Law Judge

In the Employer's Petition for Review, the Employer argued that the undersigned's failure to follow the Board's previous instructions on remand required reassignment of the case to a

new Administrative Law Judge (Emp. Br. at 2, 10, 39). In its Decision and Order, the Board granted the Employer's request "to transfer this case to another administrative law judge for a *de novo* consideration of the evidence…." *Gibbs*, BRB No. 03-0843 BLA at 6. The Board cites no statutory or case law supporting its authority to assign this case to another Administrative Law Judge. The Employer cites two cases, *Cochran v. Consolidation Coal Co.*, 16 B.L.R. 1-101 (1992), and *Hess v. Dominion Coal Corp.*, BRB No. 02-0770 BLA (Oct. 1, 2003) (unpub).

Hess is a nonbinding, unpublished case, and the Board discusses re-assignment to another Administrative Law Judge in one sentence, citing back to *Cochran*. *Hess*, BRB No. 02-0770 BLA at 10.

In *Cochran*, the Board stated that "we have the authority and the duty to order that the case be reassigned to a different administrative law judge on remand…." *Cochran*, 16 B.L.R. 1-101, 1-109. As authority, the Board cites to 20 C.F.R. §§ 802.404(a) and 802.405(a). *Id*.

Twenty C.F.R. § 802.404(a) states that:

> In its decision the Board shall affirm, modify, vacate or reverse the decision or order appealed from, and may remand the case for action or proceedings consistent with the decision of the Board. The consent of the parties shall not be a prerequisite to a remand ordered by the Board.

Twenty C.F.R. § 802.405(a) states that:

> Where a case is remanded, such additional proceedings shall be initiated and such other action shall be taken as is directed by the Board.

Neither of the regulations cited grants the Board the power to transfer cases or to control the dockets within the Office of Administrative Law Judges. The statutory power to transfer a case from one Administrative Law Judge to another Administrative Law Judge rests solely with the Chief Administrative Law Judge under 20 C.F.R. § 725.454(e) and 29 C.F.R. § 18.31(c).

"The [Benefits Review Board] … is … an adjudicatory tribunal, and Congress has conferred upon it no authority to make rules or formulate policy.… Thus the BRB's interpretations of the statutes and regulations that control its decisions are 'not entitled to any special deference from the courts.'"

Bethlehem Mines Corp. v. Director, OWCP [Simila], 766 F.2d 128, 130 (3rd Cir. 1985).

The Circuit Courts, likewise, lack the power to transfer a claim to a new Administrative Law Judge absent a provision in the Act or its regulations permitting reassignment.[1] *See, e.g., Sarchet v. Chater*, 78 F.3d 305, 309 (7th Cir. 1996) (holding that "[w]e are mindful that we have no general power comparable to our power in reviewing decisions by district judges, 7th Cir.R. 36, to order that a case decided by an administrative agency be sent back (if we reverse the decision) to a different administrative law judge."); *Travis v. Sullivan*, 985 F.2d 919, 923-24 (7th Cir. 1993).

Where the record clearly demonstrates an Administrative Law Judge's bias or partiality towards the claimant, however, Circuit Courts have recommended that the reviewing authority transfer the remand hearing to a different Administrative Law Judge. The analysis behind such a recommendation is worthy of serious reflection. Charges of bias or prejudice are not to be made lightly and must be supported by concrete evidence. *Cochran*, 16 B.L.R. at 1-108 (*citing Marcus v. Director, OWCP*, 548 F.2d 1044, 1050 (D.C. Cir. 1976), and *Zamora v. C.F.&I. Steel Corp.*, 7 B.L.R. 1-568 (1984)). For a party to succeed on the issue of Administrative Law Judge prejudice, "he would have to point to something outside the record indicating prejudgment or to [demonstrate] that the ALJ's factual findings were undermined by his animus toward[s] the [party.]" *Migliorini v. Director, OWCP*, 898 F.2d 1292, 1294 (7th Cir. 1990) (*citing Pearce v. Sullivan*, 871 F.2d 61, 63-64 (7th Cir. 1989).

The burden to show prejudice or bias is a high one. Transfer to another Judge due to bias or prejudice is appropriate when the Judge brandished "deep-seated favoritism or antagonism" (s*ee, e.g., Liteky v. United States*, 510 U.S. 540, 555 (1994)), or when the Administrative Law Judge's conduct was "coercive and intimidating" or "offensive and unprofessional." *Ventura*, 55 F.3d at 903-905. As an example, in the case cited by the Employer, the original Administrative Law Judge characterized the Employer's evidence as "obviously cumulative,

---

[1] *See, e.g., Ventura v. Shalala*, 55 F.3d 900, 902 (3rd Cir. 1995), a Social Security case where the regulations permitted petition to the Appeals Board for removal of an Administrative Law Judge. Under the applicable regulation, however, the Claimant was required to bring his objections before the Administrative Law Judge for a ruling on whether recusal was proper before appealing the matter to the Appeals Board. *See also, Alarcon-Chavez v. Ashcroft*, No. 04-60242 (5th Cir. Mar. 22, 2005) (remanding an immigration claim for flagrant abuse of discretion by the presiding Administrative Immigration Judge, but deferring to the Appeals Board on the question of whether remand to a different Immigration Judge was appropriate).

duplicative and of no probative value" and stated that the Employer's evidence represented nothing but "a powerful exhibition of financial clout to prove that anything and everything is for sale." *Cochran*, 16 B.L.R. at 1-109.[2]

No such bias or prejudice has been alleged or demonstrated in this case. No derogatory remarks at hearing or in any Decision regarding the Employer that would suggest any form of antagonism, intimidation, coercion, or unprofessional behavior have been made. The Employer points to nothing outside the record to suggest animus. Under 29 C. F. R. § 18.31(b),

> Whenever any party shall deem the administrative law judge for any reason to be disqualified to preside, or to continue to preside, in a particular proceeding, that party shall file with the administrative law judge a motion to recuse. The motion shall be supported by an affidavit setting forth the alleged grounds for disqualification. The administrative law judge shall rule upon the motion.

At no time while this claim has been before the Office of Administrative Law Judges has the Employer filed a motion for recusal. The Employer instead asserts through the appeals process that "the administrative law judge's improper failure to comply with the Board's prior remand instructions requires that … the case be reassigned to a new administrative law judge." (Emp. Br. at 2). The Employer has not requested recusal or withdrawal, and it now asks the Board to rule on a motion that is outside the Board's scope of review. *See* 20 C.F.R. § 802.301(a) (holding that the Board cannot engage in a *de novo* proceeding or unrestricted review of a case and that the Board is limited to reviewing the findings of fact and conclusions of law on which the decision or order appealed from was based).

Further, this case does not represent a continual refusal to comply with the Board's instructions. The first Decision and Order was remanded due to a failure to conduct a *de novo* review of the evidence. The Board affirmed the second Decision and Order. The Board considered the Employer's Motion for Reconsideration and found that the newly submitted evidence was

---

[2] *But see, Millburn Colliery Co. v. Hicks*, 138 F.3d 524 (4th Cir. 1998) (holding that where an Administrative Law Judge made several errors of law, did not consider all of the relevant evidence, and did not adequately explain his rationale for crediting evidence after three remands, further review of the case "requires a fresh look at the evidence, unprejudiced by the various outcomes of the [original] ALJ and Board's orders."). The *Millburn* Court cited no authority for its power to transfer the case to a new Administrative Law Judge.

improperly dismissed as cumulative and nonprobative and then remanded the claim. The third Decision and Order, the subject of the instant remand Order, remanded the case due to an improper application of the modification standard. The Board found a different reason each time to remand the case for further consideration. Again, there is no animus or bias alleged by or demonstrated towards the Employer.

On review of the recent Board Decision, I find that more specific explanation of the weight given to and credibility assigned to each individual medical opinion should have been provided in the August 27, 2003, Decision and Order on Remand. I find, however, that the Board's directive to transfer this case to another Administrative Law Judge is inappropriate. I retain jurisdiction of this case and will conduct a *de novo* review of the evidence applying the modification standard and laying out individual weight and credibility findings of the medical opinions as required by the Act and the regulations and as instructed by the Board. *See* 5 U.S.C. § 556; 30 U.S.C. § 932(a); 29 C.F.R. § 18.29; 20 C.F.R. § 725.352.

Medical Evidence

The following medical evidence was submitted for consideration subsequent to Judge Levin's September 20, 1995, Decision and Order awarding benefits:

X-ray Studies

	Date	Exhibit	Doctor	Reading	Standards
1.	08/27/97	EX 1	Broudy B reader[3]	No pneumo.	Good
2.	06/30/97	EX 6	Wiot B reader Board cert.[4]	No pneumo.	Fair

[3] A "B reader" is a physician who has demonstrated proficiency in assessing and classifying x-ray evidence of pneumoconiosis by successfully completing an examination conducted by or on behalf of the Department of Health and Human Services. *See* 42 C.F.R. § 37.51(b)(2).

[4] A Board-certified Radiologist is a physician who is certified in Radiology or Diagnostic Roentgenology by the American Board of Radiology or the American Osteopathic Association.

	Date	Exhibit	Doctor	Reading	Standards
3.	06/30/97	CX 2	Marshall B reader Board cert.	1/0 p,p	Fair
4.	06/30/97	EX 5	Spitz B reader Board cert.	No pneumo.; emphysema	Good
5.	02/18/96	DX 72	Scott, Jr. Board cert.	No pneumo.	Poor
6.	02/18/96	DX 72	Wheeler B reader Board cert.	No pneumo.	Fair
7.	02/18/96	DX 70	Hashem	Negative	Not noted
8.	10/14/95	DX 78	Sargent B reader Board cert.	No pneumo.	Good
9.	10/14/95	DX 64	Wright	0/1 q,t	Good
10.	10/14/95	DX 74	Wheeler B reader Board cert.	No pneumo.	Fair
11.	10/14/95	DX 74	Scott, Jr. Board cert.	No pneumo.	Fair
12.	09/26/95	DX 64	Powell B reader	No pneumo.	Good
13.	09/26/95	DX 75	Sargent B reader Board cert.	No pneumo.	Good
14.	06/21/95	DX 83; EX 5	Scott, Jr. B reader Board cert.	No pneumo.	Good
15.	06/21/95	DX 83; EX 5	Wheeler B reader Board cert.	No pneumo.	Good
16.	06/21/95	DX 64	Vuskovich B reader	No pneumo.	Good
17.	05/08/95	DX 70	Hashem	Emphysema	Not noted

	Date	Exhibit	Doctor	Reading	Standards
18.	05/08/95	DX 72	Wheeler B reader Board cert.	No pneumo.	Fair
19.	05/08/95	DX 72	Scott, Jr. Board cert.	No pneumo.	Fair
20.	11/30/94	DX 77	Sargent B reader Board cert.	No pneumo.	Poor
21.	11/30/94	DX 74	Wheeler B reader Board cert.	No pneumo.	Good
22.	11/30/94	DX 74	Scott, Jr. Board cert.	No pneumo.	Good

Pulmonary Function Studies

	Date	Ex.	Doctor	Age/ Height[5]	FEV_1	FVC	MVV	FEV_1/ FVC	Standards
1.	08/27/97	EX 1	Broudy Post Bronch.	57/71"	.85 .91	3.53 3.99	31 36	24% 23%	Good coop.& effort; tracings included
2.	10/14/95	DX 64	Wright	55/70"	.86	2.51	--	34%	Coop. & comp. not noted; no tracings
	Comment:	Dr. Wright stated that the study was invalid as the results do not meet the 5% repetition rule (DX 64).							
3.	09/26/95	DX 64	Powell	55/70"	1.00	2.44	45.2	41%	Fair coop.& comp.; tracings included

Arterial Blood Gas Studies

	Date	Exhibit	pCO_2	pO_2
1.	08/27/97	EX 1	40.5	59.5

[5] The factfinder must resolve conflicting heights of the miner recorded on the ventilatory study reports in the claim. *Protopappas v. Director, OWCP*, 6 B.L.R. 1-221 (1983). I find the Miner's height to be 70½".

	Date	Exhibit	pCO_2	pO_2
2.	10/22/95	DX 70	39.8	89.0
3.	10/14/95	DX 64	42.0	70.0

Narrative Medical Evidence

1. Dr. Fino was deposed by the Employer on March 30, 1998. He repeated his findings from an earlier consultative report and stated that even if the Claimant has pneumoconiosis, his opinions as to the etiology of the Claimant's severe pulmonary disability would not change. Dr. Fino opined that the Claimant does not retain the pulmonary function capacity to perform the arduous work of a coal miner (EX 7).

2. a. Dr. Bruce C. Broudy, a B reader and Board-certified Internist with a Subspecialty in Pulmonary Medicine, examined the Claimant on August 27, 1997 (EX 1). He noted the Claimant's symptoms (shortness of breath, daily cough, sputum, frequent chest pain, wheezing, dyspnea on exertion) and his occupational (23 years underground coal mine employment plus drove a coal truck for 2½ years, stopped in August 1991), medical (hospitalized for pneumonia, takes breathing medicine, hospitalized several times for breathing difficulties), and smoking (1 pack per day for 20 years, quit in 1989 or 1990) histories. Dr. Broudy's examination of the Claimant showed a diminished chest expansion, decreased aeration throughout the lungs, wheezes and rhonchi on forced expiration, and marked expiratory delay with forced expiration. He conducted pulmonary function (severe obstruction with no significant responsiveness to bronchodilation) and arterial blood gas (moderately severe resting arterial hypoxemia with elevation of the carboxyhemoglobin indicating continued exposure to smoke) studies and interpreted an x-ray (negative). Dr. Broudy diagnosed: (1) pulmonary emphysema; and, (2) severe chronic obstructive airways disease secondary to pulmonary emphysema. He attributed the diagnosed conditions to cigarette smoking. Dr. Broudy concluded:

> Because of the severe respiratory impairment due to chronic obstructive airways disease from cigarette smoking, I do not believe Mr. Gibbs retains the respiratory capacity to perform the work of an underground coal miner or to do similarly arduous manual labor.

b. Dr. Broudy was deposed by the Employer on October 17, 1997. He repeated his earlier findings and stated that pulmonary emphysema is not caused in whole or in part by the inhalation of coal mine, rock, or sand dust. Dr. Broudy opined that the Claimant's severe obstructive defect is due to cigarette smoking. Dr. Broudy stated that his conclusions would not change even if he assumed that the Claimant had coal workers' pneumoconiosis 1/0, 1/1, or 1/2 (EX 2).

c. Dr. Broudy was deposed by the Claimant on March 5, 1998. He recounted his previous findings and opined that he could distinguish the etiology of the Claimant's breathing problem from cigarette smoking or coal dust exposure. Dr. Broudy stated that he attributed the breathing problems to cigarette smoking because the Claimant does not have any evidence of pneumoconiosis on x-ray and because he has the classical findings of pulmonary emphysema and severe chronic obstructive airways disease due to cigarette smoking (CX 3).

3. a. The record contains a letter (DX 83; EX 5), dated May 29, 1997, prepared by Dr. Powell, a B reader and Board-certified Internist with a Subspecialty in Pulmonary Diseases, which states in relevant part:

> I am of the opinion that Mr. Gibbs does not have pneumoconiosis, even by the legal definition, that his obstructive airways disease did not arise out of coal mine employment in that his obstructive airways disease with its severe obstructive impairment is not significantly related to or substantially aggravated by dust exposure in coal mine employment but that it is caused by tobacco smoking in his individual susceptibility to develop chronic obstructive airways disease from tobacco smoking. I am of the opinion that he is disabled from doing manual labor because of his obstructive airways disease with its severe impairment that is due to tobacco smoking as the sole cause of that impairment and its associated disability.

b. Dr. Powell examined the Claimant on September 26, 1995. He noted the Claimant's symptoms (shortness of breath, daily cough productive of sputum, streaky hemoptysis, nonradiating substernal chest pain) and his occupational (25½ years in mining, 23 years underground, stopped in August 1991 due to shortness of breath) and smoking (smoked cigarettes at the rate of 1 pack per day from age 29 until he stopped at age 49) histories. Dr. Powell's examination of the Claimant revealed rhonchi that cleared with coughing. He conducted

pulmonary function (severe obstructive ventilatory defect) and arterial blood gas (nonqualifying) studies, interpreted an x-ray (0/0), and conducted an EKG (abnormal showing an incomplete bundle-branch block). He opined that the Claimant does not suffer from coal workers' pneumoconiosis and has a severe obstructive ventilatory defect due to pulmonary emphysema secondary to tobacco use (DX 64).

4. The record contains treatment notes prepared by Dr. Kenneth Wier covering visits by the Claimant between June 7, 1995, and January 22, 1997 (DX 71). Dr. Wier made the following diagnoses: (1) chronic obstructive pulmonary disease; (2) emphysema; (3) hypoxia; and, (4) anxiety disorder generalized.

5. The record contains treatment notes prepared by Dr. Kathleen Caizzi covering visits by the Claimant to Whitesburg Appalachian Regional Hospital (DX 70). In a Discharge Summary covering a hospital visit from October 21, 1995, to October 23, 1995, Dr. Caizzi diagnosed colitis and steroid dependent chronic obstructive pulmonary disease.

6. Dr. Ballard D. Wright, a Board-certified Anesthesiologist, examined the Claimant on October 14, 1995. He noted the Claimant's symptoms (cough productive of purulent phlegm, occasional hemoptysis, shortness of breath, frequent chest wheezing) and his occupational (23½ years in the underground mines, stopped on August 15, 1991, due to breathing problems), medical (heart disease, gastritis, back problems, arthritis, hospitalized for bronchitis, breathing problems, and pneumonia), and smoking (had smoked 1-2 packs of cigarettes for 20 years, stopped in 1989) histories. Dr. Wright's examination of the Claimant revealed end expiratory wheezing in the lung fields and scattered rhonchi which cleared with coughing. He conducted pulmonary function (severe obstructive as well as restrictive impairment) and arterial blood gas (mild resting arterial hypoxemia) studies, interpreted an x-ray (0/1 q,t), and conducted an EKG (sinus rhythm with left axis deviation and incomplete right bundle branch block). Dr. Wright stated that the diagnosis of coal workers' pneumoconiosis cannot be made. He opined that the Claimant suffered from chronic smokers' bronchitis with probable moderate severe impairment, but noted that the disability rating cannot be given due to poor test effort. Dr. Wright stated that the Claimant suffers from chronic low back pain, status post injury remote (DX 64).

Consultative Report

1. Dr. Ben V. Branscomb, a B reader and Board-certified Internist, issued a consultative report dated June 5, 1997. He reviewed the following medical evidence prior to issuing an opinion: 53 interpretations of 26 x-rays dated between April 12, 1987, and February 18, 1996; three 1992 pulmonary function studies performed by Drs. Anderson, Baker, and Myers; arterial blood gas studies; the Claimant's employment, smoking, and medical histories; and, medical examination reports by Drs. Baker, Wier, Dahhan, Caizzi, Powell, Wright, Fino, and Vuskovich. Based on a review of these records, Dr. Branscomb opined that the Claimant does not have pneumoconiosis or other occupational disease and no pulmonary impairment secondary to inhalation of dust in or around coal mines. He stated that the Claimant is not capable of continuing his previous work in coal mining and attributed his impairments to asthmatic bronchitis with acute asthmatic exacerbations caused by cigarette smoking. Dr. Branscomb noted that the following features of the Claimant's condition are not typical of coal workers' pneumoconiosis but are typical of chronic asthmatic bronchitis as seen in cigarette smokers with asthmatic tendencies: the severity of his obstruction; the increase rather than reduction in lung size; the severity, intermittency, and response to medication of his wheezing; the profound sensitivity of his bronchospasm; and, the fact that he has become steroid dependent. Even assuming that the Claimant has category 1/1 coal workers' pneumoconiosis, Dr. Branscomb stated that his conclusions would be the same with regard to the etiology of the Claimant's disability (DX 87; EX 5).

The following medical evidence was submitted prior to the September 20, 1995, Decision and Order awarding benefits.

X-ray Studies

	Date	Exhibit	Doctor	Reading	Standards
1.	11/30/94	DX 48	Baker B reader	1/0 p,p	Fair
2.	11/30/94	DX 48	Vaezy B reader	No pneumo.	Good
3.	11/30/94	DX 48	Brandon B reader Board cert.	1/0 p,p	Not noted

	Date	Exhibit	Doctor	Reading	Standards
4.	11/30/94	DX 50	Wiot B reader Board cert.	No pneumo.	Fair
5.	05/05/94	DX 74	Scott, Jr. Board cert.	No pneumo.	Good
6.	05/05/94	DX 74	Wheeler B reader Board cert.	No pneumo.	Fair
7.	05/05/94	DX 76	Sargent B reader Board cert.	No pneumo.	Good
8.	02/02/94	DX 52	Halbert B reader Board cert.	Completely negative	Good
9.	02/02/94	DX 41	Sargent B reader Board cert.	No pneumo.	Poor
10.	02/02/94	DX 40	Baker B reader	1/0 p,q	Fair
11.	12/26/93	DX 70	Kabir	No definite acute process is seen.	Not noted
12.	06/28/93	EX 4	Wiot B reader Board cert.	No pneumo.	Fair
13.	06/28/93	EX 3, 5	Spitz B reader Board cert.	Completely negative	Fair
14.	06/28/93	CX 1	Brandon B reader Board cert.	1/0 p,p	Fair
15.	03/10/93	DX 31	Dahhan B reader	No pneumo.	Good
16.	03/10/93	DX 24	Sargent B reader Board cert.	No pneumo.	Good

	Date	Exhibit	Doctor	Reading	Standards
17.	03/10/93	DX 52	Halbert B reader Board cert.	Completely negative	Fair
18.	01/27/93	DX 42	Burki	No pneumo.	Good
19.	01/11/93	DX 42	Lane B reader	Completely negative	Poor
20.	11/23/92	DX 30	Myers B reader	1/0 p,s	Good
21.	11/23/92	DX 23	Barrett B reader Board cert.	No pneumo.	Good
22.	11/23/92	DX 22	Sargent B reader Board cert.	No pneumo.	Fair
23.	11/23/92	DX 52	Wiot B reader Board cert.	No pneumo.	Good
24.	08/19/92	DX 52	Wiot B reader Board cert.	No pneumo.	Poor
25.	08/19/92	DX 21	Barrett B reader Board cert.	No pneumo.	Good
26.	08/19/92	DX 20	Sargent B reader Board cert.	No pneumo.	Fair
27.	08/19/92	DX 29	Baker B reader	1/0 q,q	Fair
28.	07/29/92	DX 28, 51	Anderson	1/0 p,q	Good
29.	07/29/92	DX 52	Halbert B reader Board cert.	Completely negative	Good
30.	07/29/92	DX 39	Sargent B reader Board cert.	No pneumo.	Good

	Date	Exhibit	Doctor	Reading	Standards
31.	03/20/92	DX 52	Wiot B reader Board cert.	No pneumo.	Fair
32.	03/20/92	DX 27	Myers B reader	1/0 p,s	Good
33.	03/20/92	DX 25, 51	Anderson	1/0 p,q	Fair
34.	03/20/92	DX 26	Baker B reader	1/0 p,p	Fair
35.	03/20/92	DX 19	Barrett B reader Board cert.	No pneumo.	Fair
36.	03/20/92	DX 18	Sargent B reader Board cert.	No pneumo.	Fair
37.	01/30/92	DX 42	Anderson	Completely negative	Poor
38.	11/12/91	DX 70	Hashem	Emphysema	Not noted
39.	06/27/91	DX 70	Hashem	Emphysema	Not noted
40.	10/21/88	DX 70	Hashem	Emphysema	Not noted
41.	10/03/88	DX 70	Hashem	Emphysema	Not noted
42.	04/12/87	DX 70	Hashem	Mild emphysema; old granulomatous disease.	Not noted

Pulmonary Function Studies

	Date	Ex.	Doctor	Age/ Hgt.	FEV_1	FVC	MVV	FEV_1/ FVC	Standards
1.	06/21/95	DX 64	Vuskovich	54/	.78	1.88	—	41%	Good coop.&
		Post-Bronch.		70.86"	.95	2.61	—	36%	comp.; tracings included.

	Date	Ex.	Doctor	Age/ Hgt.	FEV_1	FVC	MVV	FEV_1/ FVC	Standards
2.	11/30/94	DX 48	Baker	54/ 70½"	0.92	2.81	42	33%	Coop. & comp. not noted; tracings included.
3.	02/02/94	DX 40	Baker	53/ 70½"	1.19	3.13	—	38%	Coop. & comp. not noted; tracings included.
4.	03/10/93	DX 10	Dahhan	52/ 70¼"	1.24	3.29	44.1	38%	Good coop.& comp.; tracings included.
	Validation Study:		Dr. S. Kraman, a Board-certified Internist and Pulmonologist, stated that these vents are acceptable (DX 10).						
5.	11/23/92	DX 9	Myers	52/ 70.1"	1.56	3.28	47.6	48%	Maximum effort; tracings included.
6.	08/19/92	DX 8	Baker	51/ 70½"	1.62	4.16	—	39%	Coop. & comp. not noted; tracings included.

Arterial Blood Gas Studies

	Date	Exhibit	pCO_2	pO_2
1.	05/09/95	DX 70	39.4	77
2.	11/30/94	DX 48	40.4	75.4
3.	02/02/94	DX 40	38.2	72.2
4.	03/10/93	DX 17	37.2	71.8
		Exercise	36.0	82.2
5.	11/23/92	DX 16	36	82
6.	08/19/92	DX 8	40.8	63.9
7.	07/29/92	DX 11	42	69

	Date	Exhibit	pCO_2	pO_2
8.	06/30/91	DX 70	41	84
9.	06/28/91	DX 70	37	94
10.	02/07/89	DX 70	36.5	73
11.	11/01/88	DX 70	42.5	74.5

Narrative Medical Evidence

1. The record contains treatment notes prepared by Dr. Kathleen Caizzi covering visits by the Claimant to Whitesburg Appalachian Regional Hospital (DX 70). The Discharge Summary dated May 12, 1995, listed the following diagnoses: (1) chronic obstructive pulmonary disease exacerbated, steroid dependency; and, (2) acute bronchitis. A Discharge Summary dated June 30, 1991, listed a diagnosis of acute exacerbation of chronic obstructive pulmonary disease. An Emergency Record dated November 25, 1988, stated a final diagnosis of: (1) chronic obstructive pulmonary disease; (2) emphysema; and, (3) bronchial asthma. A Discharge Summary regarding an October 27, 1988, discharge listed a final diagnosis of: (1) acute asthmatic bronchitis; (2) hypoxia; (3) severe bronchospasm; and, (4) chronic obstructive pulmonary disease. A Discharge Summary regarding an October 7, 1988, discharge listed: (1) chronic obstructive pulmonary disease, exacerbated, with hemophilus; (2) influenza; and, (3) hypoxia.

2. Dr. Matt Vuskovich, a B reader, examined the Claimant on June 21, 1995. He noted the Claimant's symptoms (morning cough productive of clear to cloudy sputum, wheezing, substernal chest pain with shortness of breath, sleeps with two pillows) and his smoking (quit smoking in 1988 or 1989) history. Dr. Vuskovich's examination revealed rales and wheezing throughout both lung fields and poor lateral excursion of the lower ribs. He conducted a pulmonary function (severe impairment, obstructive pattern, little change since 8/30/94 study) study, interpreted an x-ray (0/0, evidence of chronic obstructive pulmonary disease), and conducted an EKG (sinus tachycardia, left axis deviation, nonspecific T wave and ST abnormalities). Dr. Vuskovich diagnosed: (1) severe chronic obstructive pulmonary disease; and, (2) severe obstructive impairment secondary to chronic obstructive pulmonary disease. He opined that the Claimant does not have an occupational lung disease caused by his coal mine employment and is not physically able, from a pulmonary standpoint, to do his usual coal mine

employment or comparable and gainful work in a dust-free environment. He did not give an opinion as to the cause of the disability (DX 64).

3. a. Dr. Glen Baker, a Board-certified Pulmonologist, examined the Claimant on November 30, 1994. He diagnosed coal workers' pneumoconiosis, mild arterial hypoxemia, chronic obstructive airways disease, and chronic bronchitis. Dr. Baker opined that the etiology of the Claimant's impairment is smoking and coal dust exposure (DX 48).

b. Dr. Baker previously examined the Claimant on February 2, 1994. He diagnosed pneumoconiosis, mild arterial hypoxemia, chronic obstructive airways disease, and chronic bronchitis. Dr. Baker concluded that the Claimant was disabled from performing manual labor such as coal mining (DX 40).

c. Dr. Baker also examined the Claimant on August 19, 1992. His examination included a complete history, physical examination, x-ray, pulmonary function test, and arterial blood gas test. Upon physical examination, Dr. Baker heard diminished breath sounds and wheezing. The x-ray was read as positive, category 1/0. Dr. Baker diagnosed pneumoconiosis. Based on his laboratory testing, he opined that the Claimant would have difficulty doing sustained manual labor, even in a dust-free environment (DX 12).

4. a. In a letter dated April 10, 1993, Dr. Dahhan, a Board-certified Pulmonologist, reviewed his previous findings and Dr. Sargent's reports. He opined that the Claimant does not have pneumoconiosis and does not retain the respiratory capacity to return to his last coal mine employment or job of comparable physical demand. He attributed the Claimant's respiratory impairment to his smoking history. Dr. Dahhan stated that the Claimant would have developed his respiratory impairment regardless of his coal dust exposure (DX 14).

b. Dr. Dahhan conducted examinations of the Claimant on January 11 and March 10, 1993. Physical examination revealed an increased AP diameter of the chest and hyperresonancy to percussion. There was reduced air entry to the lungs with diffuse expiratory wheezing. Lung volume studies revealed marked air trapping, and abnormally low values were obtained from the spirometry. An EKG revealed right ventricular hypertrophy. Dr. Dahhan found that the Claimant had a severe and disabling respiratory impairment. The cause was identified as chronic obstructive lung disease caused by smoking. The Claimant had reported smoking at the rate of one pack per day

from 1960 to 1990. Dr. Dahhan did not believe that the Claimant had pneumoconiosis (DX 15, 46).

c. Dr. Dahhan was deposed by the Employer on November 11, 1994. He testified that the Claimant had a purely obstructive lung disease, with severe obstruction and severe diffusion impairment. He opined that the Claimant no longer has the respiratory capacity for performing manual labor such as coal mining. He concluded that the Claimant has emphysema caused by cigarette smoking, but does not have pneumoconiosis (DX 46).

5. Dr. John E. Myers performed an examination on November 23, 1992. On physical examination, wheezing was heard throughout the chest, with marked impairment of air exchange. There was a trace of edema in the lower extremities. The spirometry was found to reveal a severe obstructive and mild to moderate restrictive impairment. The chest x-ray was read as category 1/0 pneumoconiosis. Dr. Myers diagnosed pneumoconiosis and chronic obstructive pulmonary disease. He concluded that the Claimant was not responding to treatment well enough to be capable of returning to manual labor (DX 13).

6. a. Dr. William H. Anderson, a Board-certified Internist and Pulmonologist, examined the Claimant on July 29, 1992. He obtained a complete medical and occupational history in addition to his physical examination and laboratory testing. He read the x-ray as positive for pneumoconiosis, category 1/0. The spirometry was considered to be invalid due to excessive variation in the tracings. An EKG was normal, as were the arterial blood gases. Dr. Anderson diagnosed pulmonary emphysema and early pneumoconiosis. He opined that the Claimant retained the pulmonary capacity to perform coal mine work, stating that the Claimant did not demonstrate an inability to do so (DX 11).

b. Dr. Anderson was deposed by the Employer on March 21, 1995. He testified that he had seen the Claimant for a second examination on May 5, 1994. The report of the second examination was attached as an exhibit to the transcript of the deposition. He testified that the Claimant has a totally disabling respiratory impairment. His pulmonary diagnosis included emphysema and early pneumoconiosis. He said that the Claimant's abnormal pulmonary function is due only to centrilobular and panlobar emphysema. Dr. Anderson explained that his conclusion as to the cause of the Claimant's pulmonary problems is based in significant measure on the highly elevated residual volume, indicating air trapping within the lungs. Dr. Anderson concluded that the Claimant had early category 1

pneumoconiosis and far advanced pulmonary emphysema with cor pulmonale (DX 51).

Consultative Report

1. Gregory J. Fino, a B reader and Board-certified Internist with a Subspecialty in Pulmonary Disease, issued a consultative report dated March 23, 1995. He reviewed the following medical evidence prior to issuing an opinion: 20 interpretations of x-rays dated between January 30, 1992, and February 2, 1994; six pulmonary function studies dated 1992-1994 conducted by Drs. Anderson, Baker, Myers, and Dahhan; five arterial blood gas studies dated 1992-1994 conducted by Drs. Anderson, Baker, and Myers; the Claimant's work history and background information; and, medical narratives prepared by Drs. Anderson, Baker, Myers, and Dahhan. He stated that the July 29, 1992, pulmonary function study was not acceptable due to a premature termination to exhalation, a lack of reproducibility in the expiratory tracings, and a lack of an abrupt onset to exhalation. Based on a review of this information, Dr. Fino opined that the Claimant does not suffer from an occupationally acquired pulmonary condition as a result of coal mine dust exposure. He stated that the Claimant has a severe pulmonary disability arising out of the inhalation of cigarette smoke which is unrelated to the inhalation of coal mine dust (DX 49; EX 7).

Modification

Section 22 of the Longshore and Harbor Workers' Compensation Act, 33 U.S.C. § 922, as incorporated into the Black Lung Benefits Act by 30 U.S.C. § 932(a) and as implemented by 20 C.F.R. § 725.310, provides that upon a miner's own initiative, or upon the request of any party on the grounds of a change in condition or because of a mistake in a determination of fact, the fact-finder may, at any time prior to one year after the date of the last payment of benefits or any time before one year after the denial of a claim, reconsider the terms of an award of a denial of benefits. Section 725.310(a).

In deciding whether a mistake in fact has occurred, the United States Supreme Court stated that the Administrative Law Judge has "broad discretion to correct mistakes of fact, whether demonstrated by wholly new evidence, cumulative evidence, or merely further reflection on the evidence initially submitted." *O'Keeffe v. Aerojet-General Shipyards, Inc.*, 404 U.S. 254, 256 (1971). A modification petition need not specify any factual errors or change in conditions and, indeed, the Claimant may merely allege that the ultimate fact - total disability due to

pneumoconiosis - was wrongly decided and request that the record be reviewed on that basis. The "adjudicator has the authority, if not the duty, to reconsider all the evidence for any mistake of fact or change in conditions." *Consolidation Coal Co. v. Director, OWCP*, 27 F.3d 226 (6th Cir. 1994); *see also, Old Ben Coal Co. v. Director, OWCP [Hilliard]*, 292 F.3d 533, 22 B.L.R. 2-429 (7th Cir. 2002).

In determining whether a change in condition has occurred requiring modification of the prior denial, the Board has stated that:

> … the administrative law judge is obligated to perform an independent assessment of the newly submitted evidence, considered in conjunction with the previously submitted evidence, to determine if the weight of the new evidence is sufficient to establish at least one element of entitlement which defeated entitlement in the prior decision.

Kingery v. Hunt Branch Coal Co., 19 B.L.R. 1-6 (1994). Furthermore,

> … if the newly submitted evidence is sufficient to establish modification …, the administrative law judge must consider all of the evidence of record to determine whether the Claimant has established entitlement to benefits on the merits of the claim.

Kovac v. BCNR Mining Corp., 14 B.L.R. 1-156 (1990). Modified on recon., 16 B.L.R. 1-71 (1992).

Judge Levin's Decision and Order resulted in an award of benefits. The Circuit Courts and Benefits Review Board have held that, for purposes of establishing modification, the phrase "change in conditions" refers to a change in the claimant's physical condition. *See General Dynamics Corp. v. Director, OWCP*, 673 F.2d 23 (1st Cir. 1982); *Director, OWCP v. Drummond Coal Co.*, 831 F.2d 240 (11th Cir. 1987). Because pneumoconiosis is a progressive and irreversible disease, there can be no showing of a change in conditions. That is, the Claimant cannot recover from an irreversible disease. Therefore, I will review the evidence, old and new together, to determine whether a mistake in determination of fact was made in the prior decision awarding benefits.

In order to establish entitlement to benefits in a living miner's claim pursuant to 20 C.F.R. § 718, the claimant must establish that he suffers from pneumoconiosis, that the

pneumoconiosis arose out of coal mine employment, and that the pneumoconiosis is totally disabling. *See* 20 C.F.R. §§ 718.3, 718.202, 718.203, 718.204; *Peabody Coal Co. v. Hill*, 123 F.3d 412, 21 B.L.R. 2-192 (6th Cir. 1997); *Trent v. Director, OWCP*, 11 B.L.R. 1-26 (1987). Failure to establish any of these elements precludes entitlement. *Perry v. Director, OWCP*, 9 B.L.R. 1-1 (1986) (*en banc*).

Section 718.202 provides four means by which pneumoconiosis may be established. Under § 718.202(a)(1), a finding of pneumoconiosis may be made on the basis of x-ray evidence.

The newly submitted x-ray evidence includes 22 interpretations of eight x-ray films.

The Board has held that an Administrative Law Judge is not required to defer to the numerical superiority of x-ray evidence, *Wilt v. Wolverine Mining Co.*, 14 B.L.R. 1-65 (1990), although it is within his or her discretion to do so, *Edmiston v. F&R Coal Co.*, 14 B.L.R. 1-65 (1990). However, "administrative factfinders simply cannot consider the quantity of evidence alone, without reference to a difference in the qualifications of the readers or without an examination of the party affiliation of the experts." *Woodward v. Director, OWCP*, 991 F.2d 314 (6th Cir. 1993).

Interpretations of B readers are entitled to greater weight because of their expertise and proficiency in classifying x-rays. *Vance v. Eastern Assoc. Coal Corp., Aimone v. Morrison Knudson Co.*, 8 B.L.R. 1-32 (1985); 8 B.L.R. 1-68 (1985). Physicians who are Board-certified Radiologists as well as B readers may be accorded still greater weight. *Woodward v. Director, OWCP*, 991 F.2d 314, 316 n.4 (6th Cir. 1993).

The August 27, 1997, x-ray was read as negative by Dr. Broudy, a B reader.

The June 30, 1997, x-ray was read as negative by Drs. Wiot and Spitz, both Board-certified Radiologists and B readers, and as positive by Dr. Marshall, a Board-certified Radiologist and B reader. Noting identical credentials, I give greater weight to the two negative readings over the one positive reading, and find that the June 30, 1997, x-ray evidence is negative for pneumoconiosis.

The February 18, 1996, x-ray was read as negative by Dr. Wheeler, a Board-certified Radiologist and B reader, as negative by Dr. Scott, Jr., a Board-certified Radiologist, and

as negative by Dr. Hashem, who presents no radiographic specialty credentials.

The October 14, 1995, x-ray was read as negative by Drs. Sargent and Wheeler, Board-certified Radiologists and B readers, as negative by Dr. Scott, Jr., a Board-certified Radiologist, and as negative by Dr. Wright, who lists no radiographic specialty credentials.[6]

The September 26, 1995, x-ray was read as negative by Dr. Sargent, a Board-certified Radiologist and B reader, and as negative by Dr. Powell, a B reader.

The June 21, 1995, x-ray was read as negative by Drs. Scott and Wheeler, dually certified physicians, and as negative by Dr. Vuskovich, a B reader.

The May 8, 1995, x-ray was read as negative by Drs. Scott and Wheeler, dually certified physicians, and as negative by Dr. Hashem, who lists no radiographic credentials.

The November 30, 1994, x-ray was read as negative by Drs. Wheeler, Scott, and Sargent.

Each of the eight newly submitted x-rays is negative for pneumoconiosis. In review of the previously submitted x-ray evidence, Judge Levin stated that:

> There are ten x-rays, seven of which have been subjected to re-readings. The greatest weight must be accorded to those readings by physicians who are either B-readers or board certified radiologists. The record includes nine positive readings but over 20 interpretations which are negative for pneumoconiosis. Moreover, a majority of readings by "B" readers and Board certified radiologists report no evidence of pneumoconiosis. Therefore, the preponderance of the radiological evidence, considered qualitatively and quantitatively, fails to sustain Claimant's burden of proof, pursuant to Section 718.202(a)91), that he has pneumoconiosis.

(DX 56 at 4).

---

[6] Dr. Wright interpreted the October 14, 1995, x-ray as 0/1. Under § 718.102(b), a chest x-ray classified as 0/1 does not constitute evidence of pneumoconiosis.

The prior record contains 42 interpretations of 18 separate x-ray films.[7] A review of the interpretations shows 10 positive readings and 32 negative readings. A review of interpretations by dually certified physicians shows 20 negative interpretations and two positive interpretations. The preponderance of the previously submitted x-ray evidence, reviewed both quantitatively and based on the reviewing physician's qualifications, is negative for pneumoconiosis.

The newly submitted x-ray evidence, considered in conjunction with the previously submitted x-ray evidence, is insufficient to establish the existence of pneumoconiosis under § 718.202(a)(1). No mistake in determination of fact was made in review of the x-ray evidence.

Section 718.202(a)(2) is inapplicable because there are no biopsy or autopsy results. Section 718.202(a)(3) provides that pneumoconiosis may be established if any one of the several presumptions are found to be applicable. In the instant case, § 718.304 does not apply because there is no x-ray, biopsy, autopsy, or other evidence of large opacities or massive lesions in the lungs. Section 718.305 is not applicable to claims filed after January 1, 1982. Section 718.306 is applicable only in a survivor's claim filed prior to June 30, 1982.

Under § 718.202(a)(4), a determination of the existence of pneumoconiosis may be made if a physician exercising reasoned medical judgment, notwithstanding a negative x-ray, finds that the miner suffers from pneumoconiosis as defined in § 718.201. Pneumoconiosis is defined in § 718.201 as a chronic dust disease of the lung, including respiratory or pulmonary impairments, arising out of coal mine employment. This definition includes both medical, or "clinical" pneumoconiosis and statutory, or "legal" pneumoconiosis.

For a physician's opinion to be accorded probative value, it must be well reasoned and based upon objective medical evidence. An opinion is reasoned when it contains underlying documentation adequate to support the physician's conclusions. *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19, 1-22 (1987). Proper documentation exists where the physician sets forth the clinical findings, observations, facts, and other data on which the diagnosis is based. *Id.* A brief and conclusory medical report which lacks supporting evidence may be discredited. *Lucostic v. United States Steel Corp.*, 8 B.L.R. 1-46 (1985); *see*

[7] Judge Levin's September 20, 1995, Decision and Order lists only 30 interpretations. The admitted record in this claim, however, lists 12 additional interpretations of x-rays dated prior to Judge Levin's decision.

also, Mosely v. Peabody Coal Co., 769 F.2d 357 (6th Cir. 1985). Further, a medical report may be rejected as unreasoned where the physician fails to explain how his findings support his diagnosis. *Oggero v. Director, OWCP*, 7 B.L.R. 1-860 (1985).

The newly submitted record contains reports from seven physicians.

Dr. Fino was deposed by the Employer in March 1998, when he repeated the findings of his earlier consultative report. He opined that the Miner does not suffer from an occupationally acquired pulmonary condition as a result of coal dust inhalation. He based his opinion in part on a majority of negative x-rays. He also relied on pulmonary function testing which showed obstruction in both large airways and small airways. He stated that "on a proportional basis, the small airway flow is more reduced than the large airway flow. This type of finding is not consistent with a coal dust related condition but is consistent with conditions such as cigarette smoking, pulmonary emphysema, non-occupational chronic bronchitis, and asthma." He opined that lung volumes showed that there is stale air trapped in the Miner's lungs due to obstruction. "This is a typical pattern that we see in individuals who have obstructive lung diseases such as emphysema, or asthma, or chronic obstructive bronchitis, or any combination of the three." He noted no impairment in oxygen transfer, and stated that the Miner's improvement on exercise was inconsistent with the fixed, permanent condition seen in pneumoconiosis. Based on the above, he opined that the Miner's pulmonary condition was due to cigarette smoking and not due to coal dust exposure.

Dr. Fino's report is well reasoned. He based his opinion on objective evidence and explained how the individual readings supported his diagnosis. Noting Dr. Fino's credentials as a Pulmonologist and B reader, I give his opinion substantial weight against a finding of pneumoconiosis.

Dr. Broudy, a Board-certified Internist, Pulmonologist, and B reader, diagnosed pulmonary emphysema and severe obstructive pulmonary airways disease due to pulmonary emphysema. He attributed these conditions to cigarette smoking. In his deposition, he stated that he based his diagnosis in part on physical findings on examination showing diminished breath sounds, expiratory delay, and rhonchi and wheezing. He opined that these findings were consistent with obstructive airways disease due to pulmonary emphysema. He stated that pulmonary emphysema is not caused in whole or in part by the inhalation of coal dust (EX 2 at 16). He opined that in the absence of

positive x-ray evidence, the spirometry and physical findings all pointed to pulmonary emphysema caused by smoking and not by coal dust exposure. He further stated that his opinion would not change even if he assumed that the Claimant had coal workers' pneumoconiosis.

Dr. Broudy's diagnosis of pulmonary emphysema due to smoking is based on objective evidence and he documented which readings supported his diagnosis. He stated that his diagnosis would not change even if the Miner was found to have coal workers' pneumoconiosis. I find Dr. Broudy's opinion to be well reasoned, and find that his opinion does not support the existence of legal or clinical pneumoconiosis.

Dr. Powell, a Board-certified Internist, Pulmonologist, and B reader, opined that the Miner does not suffer from legal or clinical pneumoconiosis. He diagnosed obstructive airways disease due to tobacco smoking. He based his obstructive airways diagnosis on pulmonary function results and a 20-year history of smoking. Dr. Powell's finding of obstructive airways disease is based on objective evidence and is consistent with the findings of all physicians of record. He based his smoking etiology on a 20-year smoking history, on an x-ray that was negative for pneumoconiosis and positive for emphysema, on the obstructive nature of the Miner's impairment, and on physical examination findings. Dr. Powell based his diagnosis of tobacco-related emphysema on objective evidence and he documented which readings supported his smoking etiology. Noting Dr. Powell's credentials as a Pulmonologist, I give his opinion great weight.

The record contains six pages of treatment notes from Dr. Kenneth Wier, who lists no medical specialty credentials, dating from June 7, 1995, through January 22, 1997. In five examinations, Dr. Wier diagnosed chronic obstructive pulmonary disease, emphysema, hypoxia, and general anxiety disorder. One arterial blood gas study is mentioned, but the results are not listed. No x-rays or pulmonary function tests were performed. He did not list the basis of his diagnosis, nor did he offer an etiology of the diagnosed conditions. A physician's report may be rejected where the basis for the physician's opinion cannot be determined. *Cosaltar v. Mathies Coal Co.*, 6 B.L.R. 1-1182 (1984). Noting Dr. Wier's lack of pulmonary credentials, I find that his report is undocumented and conclusory and I give his opinion little weight.

The record contains treatment notes from Dr. Kathleen Caizzi, who lists no medical specialty credentials, covering hospital visits by the Claimant to Whitesburg Appalachian

Regional Hospital. A discharge summary dated May 12, 1995, listed an x-ray showing emphysema, a diagnosis of COPD, and a "positive history of coal miner's pneumoconiosis and tobacco use." No basis was given for the pneumoconiosis diagnosis and no etiology was given for any condition. *Cosaltar, supra.* I find her treatment notes to be unsupported and unreasoned, and I give her opinion little weight.

Dr. Wright, a Board-certified Anesthesiologist, examined the Claimant on October 14, 1995, and performed a chest x-ray, pulmonary function test, arterial blood gas study, and an EKG. In his written report, he interpreted the Claimant's x-ray as 0/1. He opined that pulmonary function testing showed obstructive and restrictive impairment, and that arterial blood gases showed mild resting hypoxemia. In diagnosing disability, Dr. Wright opined that his pulmonary function test was invalid due to poor effort because the results do not meet the 5% repetition rule. He concluded that:

> Although the patient has minimal changes on x-ray, they are not sufficient enough to make a diagnosis of Coal Workers' Pneumoconiosis, (1/0), however, the patient has a long history of pulmonary problems which probably relate to smoking. These are responsible for changes seen on lung testing; however, it is probable the patient's pulmonary studies would be improved if he had given adequate effort, and if a bronchodilator study was performed.

Dr. Wright made a diagnosis based, in part, on pulmonary function testing and then invalidated his own test due to poor effort. In his report, he opines that the Miner's x-ray was 0/1, and then in his conclusion he appears to change his opinion or mistype the interpretation as 1/0. His 0/1 reading is a negative interpretation under the regulations, while 1/0 is a positive interpretation. Twenty C.F.R. § 718.102(b). A report may be given little weight where it is internally inconsistent and inadequately reasoned. *Mabe v. Bishop Coal Co.*, 9 B.L.R. 1-67 (1986); *Cranor v. Peabody Coal Co.*, 22 B.L.R. 1-1 (1999) (*en banc* on recon.). Dr. Wright opined that the Miner's pulmonary problems "probably" relate to smoking. A physician's opinion may be given little weight if it is equivocal or vague. *Griffith v. Director, OWCP*, 49 F.3d 184 (6th Cir. 1995) (treating physician's opinion entitled to little weight where he concluded that the miner "probably" had black lung disease); *see also, Justice v. Island Creek Coal Co.*, 11 B.L.R. 1-91 (1988); *Parsons v. Black Diamond Coal Co.*, 7 B.L.R. 1-236 (1984). Noting Dr. Wright's partial reliance on invalid pulmonary function testing, his internally inconsistent x-ray interpretation, and

his equivocal etiology determination, I find Dr. Wright's opinion to be unreasoned and entitled to little weight.

Dr. Branscomb, a Board-certified Internist and B reader, was a nonexamining physician. A nonexamining physician's opinion may constitute substantial evidence if it is corroborated by the opinion of an examining physician or by the evidence considered as a whole. *Newland v. Consolidation Coal Co.*, 6 B.L.R. 1-1286 (1984). In review of the medical records, Dr. Branscomb opined that the Miner does not suffer from clinical or legal pneumoconiosis. He stated that the Miner's objective testing was not typical of pneumoconiosis but was typical of chronic asthmatic bronchitis as seen in cigarette smokers with asthmatic tendencies. In support of his diagnosis, he stated that the severity of the Miner's obstruction, the increase rather than decrease in lung size, the severity, intermittency and response to medication for the Miner's wheezing, the profound sensitivity of his bronchospasm, and the steroid dependent nature of the Miner's condition are inconsistent to the obstructive manifestations associated with coal dust exposure.

Dr. Branscomb based his opinion on objective evidence. He discussed which physician's findings he found relevant and persuasive and he wrote a well-documented conclusion discussing which testing results and physical examination findings supported his diagnosis of no pneumoconiosis. Noting Dr. Branscomb's credentials as an Internist, I give great weight to his consultative opinion.

Drs. Fino, Powell, and Broudy, Pulmonary Specialists and B readers, provide well-reasoned opinions, based upon objective medical evidence, that the Claimant does not suffer from pneumoconiosis as defined in § 718.201. This is corroborated by the well-reasoned consultative opinion of Dr. Branscomb. The opinion of Dr. Wright is not well supported and not well reasoned. The treatment notes from Drs. Wier and Caizzi do not support a finding of pneumoconiosis. I find that newly submitted medical narratives do not support the existence of pneumoconiosis under § 718.202(a)(4).

As the weight of the newly submitted narrative evidence does not support the existence of pneumoconiosis under § 718.202(a)(4), the newly submitted narratives must be weighed in conjunction with the previously submitted opinions to determine whether a mistake in determination of fact was made in the prior award. *Gibbs*, BRB No. 03-0843 BLA at 6.

In Judge Levin's September 20, 1995, Decision and Order, he held that:

> The most persuasive and well reasoned of the [previously submitted] medical opinions is that of Dr. William Anderson, who conducted two examinations, wrote thorough reports and testified at length in his deposition. Dr. Anderson has published extensively on pulmonary medicine in peer reviewed medical journals. The esteem in which he is held is evidenced from his position as Professor Emeritus at the University of Louisville School of Medicine. Dr. Anderson based his opinion that Claimant has pneumoconiosis upon his reading of x-rays, the miner's medical and occupational history and his laboratory testing. Dr. Anderson's opinion in that regard is buttressed by the opinions of Doctors Baker and Myers. Therefore, it is found, pursuant to Section 718.202(a)(4), that Claimant has established the existence of pneumoconiosis.

(DX 56 at 6-7).

Dr. Anderson, a Board-certified Internist and Pulmonologist, examined the Claimant in 1992 and 1994, and testified by deposition. He diagnosed pulmonary emphysema and early pneumoconiosis. In the 1992 exam, Dr. Anderson noted 25 years of coal mine employment, 30 years of smoking at a rate of about a pack of cigarettes per day, and clear lungs with the exception of the end expiratory maneuver which caused the Claimant to cough. He read the July 29, 1992, x-ray as positive 1/0. Dr. Anderson invalidated his pulmonary function test due to variability in the curves showing poor effort. Arterial blood gases and EKG were normal.

In the 1994 examination, he read the Claimant's x-ray as positive 1/0. He opined that the 1994 pulmonary test was valid and that it produced abnormal readings indicating pulmonary emphysema. He stated that the Claimant's residual volume was 207% of predicted, which meant that he had centrilobular and panlobular emphysema as a result of cigarette smoking. He diagnosed category 1 pneumoconiosis on the basis of an abnormal x-ray and far advanced pulmonary emphysema due to cigarette smoking.

Dr. Anderson, who lists no radiographic credentials, based his coal workers' pneumoconiosis diagnosis on a positive x-ray interpretation, while I have found that both the previous x-ray evidence and the newly submitted x-ray evidence, as read by

Board-certified Radiologists and/or B readers, is negative for pneumoconiosis. Further, the Board permits the discrediting of physician opinions amounting to no more than x-ray reading restatements. *Worhach v. Director, OWCP*, 17 B.L.R. 1-105, 1-110 (1993) (*citing Anderson v. Valley Camp of Utah, Inc.*, 12 B.L.R. 1-111, 1-113 (1989), and *Taylor v. Brown Badgett, Inc.*, 8 B.L.R. 1-405 (1985)). In *Taylor*, the Board explained that the fact that a miner worked for a certain period of time in the coal mines "does not tend to establish that he does [or does] not have any respiratory disease arising out of coal mine employment." *Taylor*, 8 B.L.R. at 1-407. When a doctor relies solely on a chest x-ray and a coal dust exposure history, his failure to explain how the duration of a miner's coal mine employment supports his diagnosis of the presence or absence of pneumoconiosis renders his or her opinion "merely a reading of an x-ray … and not a reasoned medical opinion." *Id.* As Dr. Anderson states no other reason for his diagnosis of pneumoconiosis beyond the x-ray and a history of coal dust exposure, I find his diagnosis of category 1 pneumoconiosis neither well reasoned nor well documented. I give his opinion little weight.

Dr. Anderson diagnosed pulmonary emphysema due to cigarette smoking. He based this diagnosis on his 1994 pulmonary function study. He documented the readings supporting his finding of emphysema, and he noted the residual volume reading that supported his smoking etiology. As he did not tie the Claimant's emphysema to coal dust exposure, however, this diagnosis does not support a finding of legal pneumoconiosis.

Dr. Meyers, a Board-certified Internist and Pulmonologist, examined the Claimant in 1992. He noted 25 years of coal mine employment and 25 years of cigarette smoking at a rate of one pack per day, quitting in 1989. On examination, he noted wheezing and marked impairment of air exchange. He interpreted the Miner's November 23, 1992, x-ray as positive (1/0), performed a pulmonary function test (severe obstructive, mild to moderate restrictive defect), an arterial blood gas test (normal), and an EKG (left axis deviation, incomplete right bundle branch block). He diagnosed coal workers' pneumoconiosis based on an abnormal x-ray and he diagnosed chronic obstructive pulmonary disease demonstrated by pulmonary function results.

Dr. Meyers, who lists no radiographic credentials, based his coal workers' pneumoconiosis diagnosis on a positive x-ray interpretation, when I have found that both the previous x-ray evidence and the newly submitted x-ray evidence, as read by Board-certified Radiologists and/or B readers, is negative for pneumoconiosis. As described above, his diagnosis amounts to no

more than an x-ray restatement. *Worhach, Anderson, Taylor, supra.* As Dr. Myers states no reason for his diagnosis of pneumoconiosis beyond the abnormal x-ray and a history of coal dust exposure, I find his diagnosis of category 1 pneumoconiosis neither well reasoned nor well documented. I give his opinion little weight.

Dr. Myers also diagnosed COPD, but he did not tie the ailment to coal dust exposure. As such, this diagnosis does not support a finding of legal pneumoconiosis.

Dr. Baker, a Board-certified Internist and Pulmonologist, examined the Claimant twice in 1994 and once in 1992. In his 1992 examination, he noted 25 years of coal mine employment and a smoking history of 20-25 years at a rate of one pack per day, quitting approximately 1989. Lungs showed diminished breath sounds with wheezes. He interpreted his August 19, 1992, x-ray as positive for pneumoconiosis (1/0), and performed a pulmonary function study (borderline moderate to severe obstructive ventilatory defect) and an arterial blood gas study (moderate to moderately severe resting hypoxemia). He diagnosed coal workers' pneumoconiosis, 1/0, based on an abnormal x-ray and a history of coal dust exposure. He also diagnosed COPD based on pulmonary function study, resting arterial hypoxemia based on arterial blood gas study, and chronic bronchitis based on history.

In his February 2, 1994, examination, Dr. Baker noted bilateral inspiratory and expiratory wheezes. He read the Claimant's x-ray as positive (1/0), and performed a pulmonary function study (severe obstructive defect) and an arterial blood gas study (mild resting hypoxemia). Dr. Baker again diagnosed coal workers' pneumoconiosis based on an abnormal x-ray and a history of coal dust exposure. He also diagnosed COPD based on pulmonary function study, resting arterial hypoxemia based on arterial blood gas study, and chronic bronchitis based on history. He did not give an etiology to any of these three conditions.

In his November 30, 1994, examination, Dr. Baker noted bilateral inspiratory and expiratory wheezes. He read the November 30, 1994, x-ray film as positive (1/0), and conducted a pulmonary function test (severe obstructive ventilatory defect) and an arterial blood gas test (mild resting arterial hypoxemia). Dr. Baker diagnosed coal workers' pneumoconiosis based on an abnormal x-ray and a history of coal dust exposure. He diagnosed COPD based on pulmonary function study, resting arterial hypoxemia based on arterial blood gas study, and chronic bronchitis based on history. He opined that the Miner's

COPD and chronic bronchitis are due to a 20+ pack year history of smoking and 23 years of coal dust exposure.

Dr. Baker's opinion is not well reasoned. He based his coal workers' pneumoconiosis diagnosis on an abnormal x-ray and a history of coal dust exposure. Dr. Baker lists no radiographic credentials. I have found the previously submitted and the newly submitted x-ray evidence as read by the most qualified physicians to be negative. Dr. Baker's coal workers' pneumoconiosis diagnosis amounts to no more than an x-ray restatement. *Worhach, Anderson, Taylor, supra.* As Dr. Baker states no reason for his diagnosis of pneumoconiosis beyond an abnormal x-ray and a history of coal dust exposure, I find his diagnosis of coal workers' pneumoconiosis neither well reasoned nor well documented.

Dr. Baker also diagnosed COPD and chronic bronchitis due to smoking and coal dust exposure. Such diagnoses, if reasoned, would conform to the legal definition of pneumoconiosis.

Dr. Baker based his COPD diagnosis on pulmonary function testing. As such, it is based on objective evidence. He offers no support or explanation, however, for his dual etiology finding. An opinion which fails to adequately address all possible forms of causation is undocumented, unreasoned, and of little or no probative value. *Cannelton Industries, Inc. v. Director, OWCP [Frye]*, Case No. 03-1232 (4th Cir. Apr. 5, 2004) (unpub). I find Dr. Baker's diagnosis of COPD to be well reasoned and based on objective evidence. As his etiology diagnosis is unsupported, however, I find that this diagnosis does not support a finding of legal pneumoconiosis.

Dr. Baker diagnosed chronic bronchitis "by history." He does not list the history relied on, and he lists no objective evidence to support either his diagnosis or his dual smoking/coal dust etiology. I find this diagnosis to be undocumented, unsupported, and unreasoned.

Dr. Dahhan, a Board-certified Internist and Pulmonologist, examined the Claimant twice in 1993, produced a supplemental report in April 1993, and was deposed by the Employer in 1994. He opined that the Miner suffers from emphysema caused by smoking. He based his diagnosis and his smoking etiology opinion on physical examination findings (increased AP diameter, hyperresonancy to percussion, reduced air entry, air trapping, wheezing), on pulmonary function studies (severe obstruction and diffusion impairment), and on an EKG showing right ventricular hypertrophy. He noted negative chest x-rays for pneumoconiosis and a smoking history of over 30 pack years.

Dr. Dahhan based his diagnosis on objective testing, and he identified the results that support his smoking etiology. Noting Dr. Dahhan's superior credentials, I give his opinion great weight.

Dr. Vuskovich, a B reader, examined the Claimant in 1995. He diagnosed severe chronic obstructive pulmonary disease and severe obstructive impairment. He opined that the Miner does not suffer from an occupational lung disease. He based his opinion on a negative x-ray, physical findings on examination, and a pulmonary function study. He did not list the Miner's employment history and noted only that the Miner quit smoking in 1988 or 1989. Dr. Vuskovich did not list an etiology for the COPD diagnosed. As such, it cannot support a finding of legal pneumoconiosis. Noting Dr. Vuskovich's lack of pulmonary credentials, his failure to list an etiology for the COPD diagnosed, and his lack of documentation regarding employment and smoking history, I give Dr. Vuskovich's opinion little weight.

Treatment records prepared by Dr. Caizzi covering visits by the Claimant to Whitesburg Appalachian Regional Hospital list diagnoses of chronic obstructive pulmonary disease, emphysema, bronchial asthma, hypoxia, hemophilus, influenza, and severe bronchospasm. The objective testing underlying these diagnoses is generally nonexistent, and Dr. Caizzi does not tie the diagnoses made to coal dust exposure. I find that the treatment notes of Dr. Caizzi do not support the existence of pneumoconiosis.

In review of the prior evidence, Dr. Dahhan submitted a well-reasoned opinion, based on objective evidence, demonstrating that the Miner does not suffer from pneumoconiosis as defined in § 718.202. The opinions of Drs. Anderson, Myers, Baker, and Vuskovich all suffer from serious deficiencies and they are not well reasoned. I find that newly submitted evidence, when reviewed in conjunction with previously submitted evidence, shows that a mistake in determination of fact was made on the existence of pneumoconiosis under § 718.202(a)(4). The evidence does not support the existence of pneumoconiosis.

Causal Connection Between Pneumoconiosis and Coal Mine Work

The Claimant has not established the existence of pneumoconiosis. Therefore, the question of whether it is caused by his coal mine employment is moot. The evidence necessarily fails to establish this element of the claim. I find that a mistake in determination of fact was made on the issue of

pneumoconiosis arising out of coal mine employment under § 718.203.

Total Disability

Total disability is defined as the miner's inability, due to a pulmonary or respiratory impairment, to perform his or her usual coal mine work or engage in comparable gainful work in the immediate area of the miner's residence. Section 718.204(b)(1)(i) and (ii). The Claimant must establish by a preponderance of the evidence that his pneumoconiosis was at least a contributing cause of his total disability. *See, e.g., Jewell Smokeless Coal Corp. v. Street*, 42 F.3d 241 (4th Cir. 1994). Total disability can be established pursuant to one of the four standards in § 718.204(b)(2) or through the irrebuttable presumption of § 718.304, which is incorporated into § 718.204(b)(1). The presumption is not invoked here because there is no x-ray evidence of large opacities and no biopsy or equivalent evidence.

Where the presumption does not apply, a miner shall be considered totally disabled if he meets the criteria set forth in § 718.204(b)(2), in the absence of contrary probative evidence. The Board has held that under § 718.204(c), the precursor to § 718.204(b)(2), all relevant probative evidence, both like and unlike, must be weighed together, regardless of the category or type, to determine whether a miner is totally disabled. *Shedlock v. Bethlehem Mines Corp.*, 9 B.L.R. 1-195, 1-198 (1986); *Rafferty v. Jones & Laughlin Steel Corp.*, 9 B.L.R. 1-231, 1-232 (1987).

Section 718.204(b)(2)(i) permits a finding of total disability when there are pulmonary function studies with FEV_1 values equal to or less than those listed in the tables and either:

1. FVC values equal to or below listed table values; or,
2. MVV values equal to or below listed table values; or,
3. A percentage of 55 or less when the FEV_1 test results are divided by the FVC test results.

In the September 20, 1995, Decision and Order, the Administrative Law Judge found that "[t]he valid pulmonary function studies meet the qualifying standards of Appendix B, establishing that Claimant suffers from a totally disabling pulmonary disease" (DX 56 at 7).

The newly submitted record contains three pulmonary function studies. The fact-finder must determine the

reliability of a study based upon its conformity to the applicable quality standards, *Robinette v. Director, OWCP*, 9 B.L.R. 1-154 (1986), and must consider medical opinions of record regarding reliability of a particular study. *Casella v. Kaiser Steel Corp.*, 9 B.L.R. 1-131 (1986). Dr. Wright invalidated his October 14, 1995, test due to variable results indicating inconsistent effort. Effort and cooperation were not listed, nor were tracings included with this study. I find Dr. Wright's October 14, 1995, pulmonary function study to be nonconforming, and I give it no probative weight. The remaining two pulmonary function tests produced qualifying values. Newly submitted pulmonary function evidence supports total disability.

The prior record contains six pulmonary function studies. All six studies produced qualifying readings. In comparing the newly submitted evidence to the previously submitted evidence, I find that no mistake in determination of fact was made in review of pulmonary function evidence. Pulmonary function evidence supports total disability.

Total disability may be found under § 718.204(b)(2)(ii) if there are arterial blood gas studies with results equal to or less than those contained in the tables.

In Judge Levin's September 20, 1995, Decision and Order, he found that "[a]ll of these [arterial blood gas] results are nonqualifying in terms of disability under the Appendix C tables" (DX 56 at 8).

The newly submitted record contains three arterial blood gas studies. The August 27, 1997, test produced qualifying readings. The October 22, 1995, and the October 14, 1995, tests produced nonqualifying readings. The preponderance of newly submitted arterial blood evidence is nonqualifying.

The previously submitted record contains 11 arterial blood gas studies. All 11 tests are nonqualifying. I find that no mistake in determination of fact was made in review of arterial blood gas evidence. Arterial blood gas evidence does not support total disability.

There is no evidence presented, nor do the parties contend that the Claimant suffers from cor pulmonale or complicated coal workers' pneumoconiosis.

Under § 718.204(b)(2)(iv) total disability may be found if a physician exercising reasoned medical judgment, based on medically acceptable clinical and laboratory diagnostic techniques, concludes that a miner's respiratory or pulmonary

condition prevented the miner from engaging in his usual coal mine work or comparable and gainful work.

In review of the prior medical narrative evidence, Judge Levin found in his September 20, 1995, Decision that:

> Upon this record, the examining physicians are unanimous in their opinion that Claimant no longer possesses the pulmonary capacity to perform manual labor such as his last coal mine employment. Consequently, although Claimant's blood gas results may be viewed as 'contrary' evidence, pulmonary function data and the physicians who have evaluated Mr. Gibbs establish that he is totally disabled pursuant to Section 718.204(c)(1) and (c)(4).

(DX 56 at 8).

In determining the etiology of the Miner's disability, Judge Levin held that:

> In evaluating the etiology of the Claimant's impairment, Dr. Anderson observed that it is medically feasible to distinguish the pulmonary impairment caused by the inhalation of coal mine dust from that caused by cigarette smoking 'especially when we have residual lung volume results.' … Dr. Anderson, however, did not address the clinical findings of Dr. Myers who noted data which revealed both an obstructive and a restrictive component to Claimant's impairment. Thus while 'air trapping' due to cigarette smoking may account for a significant portion of Claimant's impairment, his pulmonary function tests, according to Drs. Baker and Myers, also yield data indicative of both an obstructive and a restrictive impairment which they attribute to both cigarette smoking and coal dust exposure. Since Claimant's clinical tests reveal more than simply 'air trapping,' but both obstructive and restrictive impairments as described by Dr. Myers, I have accorded the etiology assessments of Drs. Myers and Baker greater weight than the contrary assessment by Dr. Anderson. I find based upon the opinions of Drs. Myers and Baker that Mr. Gibbs' total disability is due in part to pneumoconiosis arising out of coal mine employment within the meaning of 20 C.F.R. § 718.204(b) and (c)(4).

(DX 56 at 9).

The newly submitted record contains seven medical narratives.

Dr. Wright did not make a total disability finding due to an invalid pulmonary function test in his examination. Treatment notes prepared by Drs. Caizzi and Wier also do not make a total disability determination. A physician's report that is silent as to a particular issue is not probative of that issue. *Island Creek Coal Co. v. Compton*, 211 F.3d 203 (4th Cir. 2000).

Dr. Fino, a Board-certified Internist and Pulmonologist, opined in his deposition that the Miner was totally disabled due to cigarette smoking. He based his total disability finding on pulmonary function testing. He based his smoking etiology on the obstructive nature of the disability as shown by very low FEV_1 values. He explained that the reversibility shown with bronchodilators and the fact that the Miner was showing improvement while being medicated with steroids and inhalers, was consistent with a reversible cigarette smoking-related impairment, but less consistent with a permanent coal dust-related impairment. He noted the variability shown in arterial blood gases and opined that while arterial blood gas readings were nonqualifying, they were also abnormal and inconsistent. This demonstrated mild hypoxemia and the inconsistent degree of impairment demonstrated by the variability of the arterial blood gas readings was inconsistent with the fixed permanent nature of a coal dust-related impairment, but was consistent with a partially reversible condition caused by cigarette smoking. These results, coupled with negative x-ray evidence, demonstrated a purely smoking-related impairment.

Dr. Fino based his total disability finding on objective pulmonary function testing. He documented which readings supported his findings and explained in detail how the objective evidence supported a cigarette smoking etiology and did not support a coal dust-related etiology. Noting Dr. Fino's superior credentials, I give his opinion substantial weight.

Dr. Broudy, a Board-certified Internist, Pulmonologist, and B reader, examined the Claimant in 1997, and was deposed by the Employer in 1997 and by the Claimant in 1998. Dr. Broudy opined that the Miner no longer retains the respiratory capacity to perform the work of a coal miner or to perform similarly arduous manual labor. He based his diagnosis on pulmonary function studies showing severe obstruction, on arterial blood gas readings showing moderately severe hypoxemia, and on physical examination findings showing diminished chest expansion,

decreased aeration, wheezes, rhonchi, and marked expiratory delay with forced expiration. He opined that the Miner's disabling pulmonary impairment was due to cigarette smoking and not due to coal dust exposure. He based his smoking etiology on negative x-ray evidence, the fact that the Miner had elevated carboxyhemoglobin results (indicating continued smoking) despite the Claimant's assertion that he quit in 1989, and on physical findings and pulmonary function results which showed the classical findings of pulmonary emphysema and severe chronic obstructive pulmonary disease due to cigarette smoking.

Dr. Broudy based his total disability findings on objective pulmonary function and arterial blood gas testing. He explained which readings demonstrated that the Miner's total disability was due to cigarette smoking and not due to coal dust exposure. Noting Dr. Broudy's superior credentials, I give his opinion great weight.

Dr. Powell, a Board-certified Internist, Pulmonologist, and B reader, examined the Claimant and submitted a 1995 written report and a 1997 letter. He opined that "I am of the opinion that [the Claimant] is disabled from doing manual labor because of his obstructive airways disease with its severe impairment that is due to tobacco smoking as the sole cause of that impairment and its associated disability." He based his total disability finding on pulmonary function testing showing severe obstructive ventilatory defect. He based his smoking etiology on the obstructive nature of the Miner's impairment and negative x-ray evidence for coal dust-related pneumoconiosis.

Dr. Powell based his total disability diagnosis on objective evidence, namely the pulmonary function testing. While his smoking etiology is consistent with the other newly submitted physicians' assessments, Dr. Powell's smoking etiology is less supported than the opinions of Drs. Fino, Broudy, and Branscomb. Noting Dr. Powell's credentials, I give his opinion some weight.

Dr. Branscomb, a Board-certified Internist and B reader, issued a consultative report and opined that the Miner is no longer capable of continuing his previous coal mine work. He attributed the Miner's total disability to asthmatic bronchitis with acute asthmatic exacerbations caused by cigarette smoking. He based his total disability diagnosis on objective pulmonary function evidence. He opined that the following features observed in the records reviewed are not typical of coal workers' pneumoconiosis but are typical of chronic asthmatic bronchitis: the severity of the obstruction; the increase rather than reduction in lung size; the severity, intermittency,

and response to medication of his wheezing; the profound sensitivity of his bronchospasm; and, the fact that the Claimant has become steroid dependent in his treatment. Dr. Branscomb reviewed a wide array of objective evidence in forming his opinion. He then documented which readings supported both his total disability finding and his smoking etiology. Noting Dr. Branscomb's superior credentials, I give his opinion great weight.

The newly submitted evidence supports total pulmonary disability, but it does not support total disability due to pneumoconiosis.

The prior record contains the narratives of six physicians. Dr. Caizzi, in her treatment notes from Whitesburg Appalachian Regional Hospital, did not make a total disability finding. I give her opinion no weight on the issue of total disability. *Island Creek Coal Co., supra.*

Dr. Vuskovich, a B reader, opined that, from a pulmonary standpoint, the Miner is not physically able to perform his usual coal mine work or to perform comparable work in a dust-free environment. He based his total disability diagnosis on pulmonary function testing and on physical examination findings. He opined that the Miner does not have an occupationally acquired lung disease, but he did not list an etiology for the Miner's disability, nor did he document the number of years of smoking or the rate of smoking for the Claimant. I find Dr. Vuskovich's total disability finding to be based on objective evidence, but I find that he did not list a causation of the Miner's totally disabling impairment. Noting Dr. Vuskovich's lack of pulmonary credentials, I give his opinion less weight and find that his vague diagnosis does not support total disability due to pneumoconiosis.

Dr. Baker, a Board-certified Internist and Pulmonologist, opined that the Miner was totally disabled from a pulmonary standpoint from returning to his previous coal mine position or from performing sustained manual labor in a dust-free environment. He based his total disability diagnosis on pulmonary function testing showing severe obstruction, on physical examination findings of bilateral inspiratory and expiratory wheezes, and on arterial blood gas readings showing mild hypoxemia. He opined that the Miner's impairment was due to both cigarette smoking and coal dust exposure.

Dr. Baker based his total disability findings on objective evidence. He failed to explain however, the basis or reasoning for his dual smoking/coal dust etiology. An unsupported medical

conclusion is not a reasoned diagnosis. *Fuller v. Gibraltar Corp.*, 6 B.L.R. 1-1292 (1984). Noting Dr. Baker's credentials, I give his unsupported etiology diagnosis less weight. I find that Dr. Baker's opinion supports total pulmonary disability, but that it does not support total disability due to pneumoconiosis.

Dr. Dahhan, a Board-certified Internist, Pulmonologist, and B reader, opined that the Miner does not retain the respiratory capacity to perform his last coal mine job or job of similar physical demand. He based his total disability finding on pulmonary function testing showing severe obstruction and severe diffusion impairment. He opined that the Miner's impairment was due solely to smoking. He based his smoking etiology on the increased AP diameter of the chest with hyperresonancy to percussion, lung volume studies indicating air trapping, and reduced air entry into the lungs with expiratory wheezing. He opined that these findings were all indicative of a smoking-related illness but not consistent with a coal dust-related impairment. Dr. Dahhan based his total disability findings on objective evidence. He then explained the various results that supported his diagnosis that the Miner's impairment was smoking related and not due to coal dust exposure. Noting Dr. Dahhan's superior credentials, I give his opinion substantial weight.

Dr. Myers, a Board-certified Internist and Pulmonologist, examined the Miner in 1992 and opined that:

> It does not appear that this patient is going to respond well enough to treatment to be capable of return to manual labor, and he should certainly stay away from dust and tobacco smoke with his present condition.

Dr. Myers based his opinion on pulmonary function testing which he opined showed both severe obstructive and mild to moderate restrictive defect. He failed to discuss the Miner's normal arterial blood gas readings and he does not explain how findings on physical examination support his diagnosis. His disability diagnosis is vague and equivocal. He opined that the Miner "does not appear" to respond "well enough" to return to the mines and he opined that the Miner should avoid coal dust and tobacco smoke in his current condition. A physician's opinion may be given little weight if it is equivocal or vague. *Griffith v. Director, OWCP*, 49 F.3d 184 (6th Cir. 1995) (treating physician's opinion entitled to little weight where he concluded that the miner "probably" had black lung disease); *see also, Justice v. Island Creek Coal Co.*, 11 B.L.R. 1-91 (1988); *Parsons v. Black Diamond Coal Co.*, 7 B.L.R. 1-236 (1984). Further, an opinion of the inadvisability of returning to coal mine

employment because of a pulmonary condition is not the equivalent of a finding of total disability. *Zimmerman v. Director, OWCP*, 871 F.2d 564, 567 (6th Cir. 1989); *Taylor v. Evans & Gambrel Co.*, 12 B.L.R. 1-83 (1988); *Justice v. Island Creek Coal Co.*, 11 B.L.R. 1-91 (1988); *Bentley v. Director, OWCP*, 7 B.L.R. 1-612 (1984); *Brusetto v. Kaiser Steel Corp.*, 7 B.L.R. 1-422 (1984). Noting the vague and equivocal diagnosis, the diagnosis of restrictive defect when no other medical evidence supports that finding, and Dr. Myers' lack of documentation and support for his diagnosis, I give his opinion little weight.

Dr. Anderson, a Board-certified Internist, Pulmonologist, and B reader, examined the Claimant in 1992 and 1995. In 1992, he opined that the spirometry taken was invalid and that the remaining valid evidence did not demonstrate total disability. In his 1995 examination, he opined that the Miner was totally disabled due to emphysema caused by cigarette smoking. He based his 1995 total disability diagnosis on pulmonary function testing and opined that physical examination findings of wheezing, the pulmonary function test showing the Miner's FEV_1 and FVC readings at less than 55% of predicted, along with x-ray findings of emphysema and a highly elevated residual volume indicating air trapping within the lungs, all strongly suggested a smoking etiology.

Dr. Anderson based his total disability finding on objective evidence. He listed the readings that supported his smoking etiology. Noting Dr. Anderson's superior credentials, I give his opinion substantial weight.

In review of the prior medical narratives, Drs. Dahhan and Anderson, who are both Board-certified Pulmonologists, provide well-reasoned, well-supported opinions that the Miner is totally disabled due to smoking-related ailments and not due to pneumoconiosis. Drs. Baker and Vuskovich diagnosed total pulmonary disability, but their etiology analysis was unsupported. Dr. Myers' report was not well reasoned. I find that the newly submitted narrative evidence, when viewed in conjunction with previously submitted narrative evidence, demonstrates that the Miner is totally disabled, but not totally disabled due to pneumoconiosis. The Employer has demonstrated a mistake in determination of fact on the issue of total disability causation under § 718.204(c).

In review of qualifying pulmonary function testing, nonqualifying arterial blood gas testing, and the medical narratives detailed above, I find that the evidence supports

total pulmonary disability but that it does not support total disability due to pneumoconiosis.

The Employer has demonstrated a mistake in determination of fact on the issue of the existence of pneumoconiosis under § 718.202(a)(4), pneumoconiosis arising out of coal mine employment under § 718.203, and on the issue of total disability causation under § 718.204(c).

VI. Entitlement

The Employer has established a mistake in determination of fact. The Claimant, has not established the existence of pneumoconiosis, pneumoconiosis arising out of coal mine employment or that pneumoconiosis was a substantially contributing cause of his total disability. The Claimant, therefore, has not established entitlement to benefits under the Act.

VII. Attorney's Fee

The award of an attorney's fee is permitted only in cases in which the claimant is found to be entitled to benefits under the Act. Since benefits are not awarded in this case, the Act prohibits the charging of any fee to the Claimant for representation services rendered in pursuit of the claim.

VIII. ORDER

It is, therefore,

ORDERED that the Employer's request for modification is GRANTED; and, it is further,

ORDERED that the claim of Winston Gibbs, Jr., for benefits under the Act is hereby DENIED.

A

Robert L. Hillyard
Administrative Law Judge

NOTICE OF APPEAL RIGHTS: Pursuant to 20 C.F.R. § 725.481, any party dissatisfied with this Decision and Order may appeal it to the Benefits Review Board within thirty (30) days from the date of this Decision by filing a Notice of Appeal with the Benefits Review Board at P.O. Box 37601, Washington, D.C., 20013-7601. A

copy of a Notice of Appeal must also be served upon Donald S. Shire, Esq., 200 Constitution Avenue, N.W., Room N-2117, Washington, D.C., 20210.